

MDR Tracking Number: M5-04-0597-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-27-03.

The IRO reviewed office visits, hot or cold packs, electrical stimulation, paraffin bath, ultrasound therapy, and paraffin rendered from 11-14-02 through 03-07-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, hot or cold packs, electrical stimulation, paraffin bath, ultrasound therapy, and paraffin. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-07-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
11-25-02, 01-08-03, 01-10-03	97010 (3 units)	\$15.00 per unit	0.00	N	\$11.00	MFG MGR (I)(A)(9)(a)(ii)	Daily treatment log do not meet documentation of procedures criteria therefore reimbursement is not recommended.

11-25-02, 01-08-03, 01-10-03	97014 (3 units)	\$18.00 per unit	0.00	N	\$15.00	MFG MGR (I)(A)(9)(a)(ii)	Daily treatment log do not meet documentation of procedures criteria therefore reimbursement is not recommended.
11-25-02, 01-08-03, 01-10-03	97018 (3 units)	\$25.00 per unit	0.00	N	\$16.00	MFG MGR (I)(A)(9)(a)(ii)	Daily treatment log not meet docu- mentation of procedures criteria therefore reimbursement is not recommended.
11-25-02, 01-08-03, 01-10-03	97035 (3 units)	\$26.00 per unit	0.00	N	\$22.00	MFG MGR (I)(A)(9)(a)(iii)	Daily treatment log not meet docu- mentation of procedures criteria therefore reimbursement is not recommended.
11-25-02	A4265 (3 units)	\$5.00 per unit	0.00	N	DOP	MFG DME GR	Daily treatment log not meet docu- mentation of procedures criteria therefore reimbursement is not recommended.
01-08-03, 01-10-03				G			EOB does not identify which service A4265 is global to. Daily treatment log does not confirm delivery of service therefore reimbursement is not recommended.
01-08-03, 01-10-03, 02-12-03, 02-14-03	99213 (4 units)	\$60.00 per unit	0.00	N	\$48.00	MFG, E & M GR(IV)(C)(2)	Daily treatment log do not meet docu- mentation of procedures criteria therefore reimbursement is not recommended.
TOTAL		\$507.00					The requestor is not entitled to reimbursement

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 11-14-02 through 03-07-03 in this dispute.

This Decision is hereby issued this 4th day of May 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

January 7, 2004

MDR #: M5-04-0597-01
IRO Certificate No.: IRO 5055

REVISED REPORT **Corrected spelling of injured employee.** **Corrected dates of service.**

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Information Provided for Review:

Correspondence.
H&P and office notes.
Physical Therapy notes
Functional Capacity Evaluation

Brief Clinical History:

This male claimant was injured on his job on ___. He was treated in the emergency room and referred for treatment and conservative care was begun. Right wrist pain was noted along the ulnar side of the forearm.

Disputed Services:

Office visit, hot/cold pack therapy, electrical stimulation (unattended), paraffin bath, ultrasound therapy, and paraffin, during the period of 11/14/02 through 03/07/03.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatments and services in disputed as listed above were medically necessary in this case.

Rationale:

The documentation provided for review supports the therapeutic approach used in this case for the type of injury described in the file notes and the follow-up exams. The patient showed improvement during the course of treatment noted in the doctor's notes of therapeutic visits. The progression of improvement exhibited is consistent with the treatment rendered and the type of injury.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,